

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☒ New Pharmacy

☐ Ownership Change

(Please provide current license number if making changes: PH _____)

☐ Publicly Traded Corporation – Pages 1,2,3,7

☐ Partnership - Pages 1,2,5,7

☒ Non Publicly Traded Corporation – Pages 1,2,4,7

☐ Sole Owner – Pages 1,2,6,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: American Specialty Pharmacy

Physical Address: 2743 W 15th Street

Mailing Address: 2743 W 15th Street

City: Plano State: TX Zip Code: 75075

Telephone: 214 919 2090 Fax: 214 919 2091

Toll Free Number: 888 960 5376 (Required per NAC 639.708)

E-mail: JaneFTeamericanSpecialty Website: NA

Managing Pharmacist: Asita Parikh License Number: 51088

Hours of Operation:

Monday thru Friday 9 am 7 pm

Saturday 9 am 3 pm

Sunday 9 am 3 pm

24 Hours No

TYPE OF PHARMACY

SERVICES PROVIDED

Retail

☐ Hospital (# beds _____)

☐ Internet

☐ Nuclear

☒ Out of State

☐ Ambulatory Surgery Center

☐ Off-site Cognitive Services

☐ Parenteral

☐ Parenteral (outpatient)

☐ Outpatient/Discharge

☒ Mail Service

☐ Long Term Care

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- | | |
|--|--|
| <input checked="" type="checkbox"/> New Pharmacy
(Please provide current license number if making changes: PH _____) | <input type="checkbox"/> Ownership Change |
| <input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7 | <input type="checkbox"/> Partnership – Pages 1,2,5,7 |
| <input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7 | <input type="checkbox"/> Sole Owner – Pages 1,2,6,7 |
| <input checked="" type="checkbox"/> Please check box for type of ownership and complete correct part of the application. | |

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Central Avenue Pharmacy
Physical Address: 133 15th street, Pacific Grove CA 93950
Mailing Address: Same
City: _____ State: _____ Zip Code: _____
Telephone: (831) 373-1225 Fax: (831) 373-3705
Toll Free Number: 800-561-9715 (Required per NAC 639.708)
E-mail: dana@caprx.com Website: caprx.com
Managing Pharmacist: Dana Gordon License Number: PH437391

Hours of Operation:

Monday thru Friday 9 am 6 pm Saturday 10 am 2 pm
Sunday — am — pm 24 Hours —

TYPE OF PHARMACY

SERVICES PROVIDED

- | | |
|---|--|
| <input checked="" type="checkbox"/> Retail
<input type="checkbox"/> Hospital (# beds _____)
<input type="checkbox"/> Internet
<input type="checkbox"/> Nuclear
<input checked="" type="checkbox"/> Out of State
<input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> Parenteral
<input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> Outpatient/Discharge
<input checked="" type="checkbox"/> Mail Service (not mail order)
<input type="checkbox"/> Long Term Care |
|---|--|

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<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7 <input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7 Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Custom Rx Pharmacy
Physical Address: 3510 N. Ridge Rd, Ste 900
Mailing Address: same
City: Wichita State: KS Zip Code: 67205
Telephone: 316-721-2426 Fax: 316-721-4823
Toll Free Number: 1-800-786-3431 (Required per NAC 639.708)
E-mail: jgerber@customrx.net Website: customrx.net
Managing Pharmacist: Andi Rhodes License Number: I-13688

Hours of Operation:

Monday thru Friday <u>9</u> am <u>6</u> pm	Saturday <u>—</u> am <u>—</u> pm
Sunday <u>—</u> am <u>—</u> pm	24 Hours <u>NO</u>

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail <input type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> Internet <input type="checkbox"/> Nuclear <input checked="" type="checkbox"/> Out of State <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> Parenteral <input type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> Outpatient/Discharge <input checked="" type="checkbox"/> Mail Service <input type="checkbox"/> Long Term Care
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<input checked="" type="checkbox"/> New Pharmacy ** Owner is an L.L.C. <input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7 <input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7 Please check box for type of ownership and complete correct part of the application.	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: PH _____) <input type="checkbox"/> Partnership - Pages 1,2,5,7 <input type="checkbox"/> Sole Owner – Pages 1,2,6,7
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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: CVS Caremark Advanced Technology Pharmacy, L.L.C. d/b/a CVS Caremark

Physical Address: 1780 Wall Street, Mt. Prospect, IL 60056

Mailing Address: LEGAL-LICENSING: 9501 E. Shea Blvd. MC024

City: Scottsdale State: AZ Zip Code: 85260

Telephone: 847-264-7100 Fax: 847-290-1069

Toll Free Number: 866-284-9226 (Required per NAC 639.708)

E-mail: mailorderlicensing@caremark.com Website: www.caremark.com

Managing Pharmacist: Jason Richard Perry License Number: (IL) 051.289996

Hours of Operation: Toll free service available 24 hours a day, 7 days a week

Monday thru Friday 6:00 am 4:30 pm
closed

Sunday _____ am _____ pm

Saturday 6:00 am 4:30 pm

24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

- ☐ Retail
- ☐ Hospital (# beds _____)
- ☐ Internet
- ☐ Nuclear
- ☒ Out of State
- ☐ Ambulatory Surgery Center

- ☐ Off-site Cognitive Services
- ☐ Parenteral
- ☐ Parenteral (outpatient)
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☐ Sole Owner – Pages 1,2,6,7

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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Kabafusion

Physical Address: 11818 Rosecrans Avenue, No. A

Mailing Address: 11818 Rosecrans Avenue, No. A

City: Norwalk State: CA Zip Code: 90650

Telephone: (877) 577-4844 Fax: (877) 445-8821

Toll Free Number: (877) 577-4844 (Required per NAC 639.708)

E-mail: info@kabafusion.com Website: www.kabafusion.com

Managing Pharmacist: Michael Rigas License Number: (A) 36708

Hours of Operation:

Monday thru Friday 9:00 am 1:00 pm

Saturday _____ am _____ pm

Sunday _____ am _____ pm

24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

☒ Retail

☐ Off-site Cognitive Services

☐ Hospital (# beds _____)

☐ Parenteral

☐ Internet

☐ Parenteral (outpatient)

☐ Nuclear

☐ Outpatient/Discharge

☒ Out of State

☒ Mail Service

☐ Ambulatory Surgery Center

☐ Long Term Care

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<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7
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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Mission Road Pharmacy, Inc.; DBA: MRP

Physical Address: 1141 N. Mission Road

Mailing Address: 1155 N. Mission Road

City: Los Angeles State: California Zip Code: 90033

Telephone: 323-227-8883 Fax: 323-227-8882

Toll Free Number: 866-P (Required per NAC 639.708)

E-mail: Kelly@missionroadpharmacy.com Website: _____

Managing Pharmacist: Dao (kelly) X. Nguyen License Number: Nevada license: 13124

Hours of Operation:

Monday thru Friday 8 am 5 pm

Saturday _____ am _____ pm

Sunday _____ am _____ pm

24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

<input type="checkbox"/> Retail <input type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> Internet <input type="checkbox"/> Nuclear <input checked="" type="checkbox"/> Out of State <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> Parenteral <input type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> Outpatient/Discharge <input checked="" type="checkbox"/> Mail Service <input type="checkbox"/> Long Term Care
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61281

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<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7	<input type="checkbox"/> Partnership - Pages 1,2,5,7
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Integrated Health Concepts, Inc. dba Pacific Coast Pharmacy

Physical Address: 720 Aerovista Place, Suite D

Mailing Address: 720 Aerovista Place, Suite A

City: San Luis Obispo State: CA Zip Code: 93401-8707

Telephone: 866-239-3784 Fax: 800-977-9255

Toll Free Number: 866-239-3784 (Required per NAC 639.708)

E-mail: kfurphy@ihcmeds.com Website: www.pacificcoastpharmacy.com

Managing Pharmacist: Kathryn Andrusko-Furphy License Number: 40143 RPH

Hours of Operation:

Monday thru Friday 8 am 5 pm Saturday - am - pm

Sunday - am - pm 24 Hours

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail <input type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> Internet <input type="checkbox"/> Nuclear <input checked="" type="checkbox"/> Out of State <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> Parenteral <input type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> Outpatient/Discharge <input checked="" type="checkbox"/> Mail Service <input type="checkbox"/> Long Term Care
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61241

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☐ Publicly Traded Corporation – Pages 1,2,3,7

☐ Partnership - Pages 1,2,5,7

☒ Non Publicly Traded Corporation – Pages 1,2,4,7

☐ Sole Owner – Pages 1,2,6,7

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: PHARMALOGIC WYOMING, INC

Physical Address: 3480 TRIGOOD DRIVE

Mailing Address: 3480 TRIGOOD DRIVE

City: CASPER State: WY Zip Code: 82609

Telephone: 307-261-7000 Fax: 307-261-9813

Toll Free Number: 855-408-2257 (Required per NAC 639.708)

E-mail: PHARMALOGIC WY @ PHARMALOGIC.INFO Website: PHARMALOGIC.INFO

Managing Pharmacist: TANUKO USHIO License Number: 2558

Hours of Operation:

Monday thru Friday 12:00 am 5:00 pm

Saturday 4:00 am 1:00 pm

Sunday 4:00 am 1:00 pm

24 Hours ON CALL

TYPE OF PHARMACY

SERVICES PROVIDED

☐ Retail

☐ Off-site Cognitive Services

☐ Hospital (# beds _____)

☐ Parenteral

☐ Internet

☐ Parenteral (outpatient)

☒ Nuclear

☐ Outpatient/Discharge

☒ Out of State

☒ Mail Service

☐ Ambulatory Surgery Center

☐ Long Term Care

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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: PromiseCare Pharmacy
Physical Address: 605 Bakerstown Rd
Mailing Address: 605 Bakerstown Rd
City: Antioch State: TN Zip Code: 37013
Telephone: (615) 299-8920 Fax: (877) 323-9047
Toll Free Number: (877) 323-9067 (Required per NAC 639.708)
E-mail: S.webb@mypromisecare.com Website: www.PromiseCarePharmacy.com
Managing Pharmacist: Stephen Webb License Number: 12101

Hours of Operation:

Monday thru Friday 8 am 4:30 pm Saturday _____ am _____ pm
Sunday _____ am _____ pm 24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

- ☒ Retail
- ☐ Hospital (# beds _____)
- ☐ Internet
- ☐ Nuclear
- ☐ Out of State
- ☐ Ambulatory Surgery Center

- ☐ Off-site Cognitive Services
- ☐ Parenteral
- ☐ Parenteral (outpatient)
- ☐ Outpatient/Discharge
- ☒ Mail Service
- ☐ Long Term Care

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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: SUMMER TON DRUGS COMPOUNDING AND DISPENSARY
Physical Address: 115 B MAIN ST SUMMER TON SC 29148
Mailing Address: PO Box 37 SUMMER TON S.C. 29148
City: SUMMER TON State: S.C. Zip Code: 29148
Telephone: 803.485.8586 Fax: 803.488.0049
Toll Free Number: 1.800.372.5722 (Required per NAC 639.708)
E-mail: tp21-2000@48hoo.com Website: NONE
Managing Pharmacist: ERNEST E. Phillips III License Number: 11479

Hours of Operation:

Monday thru Friday 9:00am 6:00pm Saturday 9:00am 6:00pm
Sunday close close pm 24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail <input type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> Internet <input type="checkbox"/> Nuclear <input checked="" type="checkbox"/> Out of State <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> Parenteral <input type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> Outpatient/Discharge <input checked="" type="checkbox"/> Mail Service <input type="checkbox"/> Long Term Care
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61282

NEVADA STATE BOARD OF PHARMACY
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<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7
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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: TNH Pharmacy 2

Physical Address: 15211 Vanowen St #301

Mailing Address: _____

City: Van Nuys State: CA Zip Code: 91405

Telephone: 818-988-1288 Fax: 818-988-6588

Toll Free Number: 877-849-1591 (Required per NAC 639.708)

E-mail: avo@tnhpharmacy.com Website: tnhpharmacy.com

Managing Pharmacist: Nabil Daoud License Number: RPH 46516

Hours of Operation:

Monday thru Friday 9 am 5:30 pm

Saturday _____ am _____ pm

Sunday closed am _____ pm

24 Hours Yes (on call)

TYPE OF PHARMACY

SERVICES PROVIDED

<input type="checkbox"/> Retail <input type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> Internet <input type="checkbox"/> Nuclear <input checked="" type="checkbox"/> Out of State <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> Parenteral <input type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> Outpatient/Discharge <input checked="" type="checkbox"/> Mail Service <input type="checkbox"/> Long Term Care
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| <input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4,7 | <input type="checkbox"/> Sole Owner – Pages 1,2,6,7 |
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GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: USC Medical Plaza Pharmacy

Physical Address: 1510 San Pablo Street, Suite 144

Mailing Address: 1510 San Pablo Street, Suite 144

City: Los Angeles State: CA Zip Code: 90033

Telephone: (323) 442-5770 Fax: (323) 442-5970

Toll Free Number: (888) 970-5770 (Required per NAC 639.708)

E-mail: Plaza@pharmacy.usc.edu Website: www.pharmacies.usc.edu

Managing Pharmacist: Sharon Cochran License Number: (CA) 30753

Hours of Operation:

Monday thru Friday <u>8:30</u> am <u>6:00</u> pm	Saturday <u>9:00</u> am <u>1:00</u> pm
Sunday _____ am _____ pm	24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

- | | |
|---|---|
| <input checked="" type="checkbox"/> Retail
<input type="checkbox"/> Hospital (# beds _____)
<input type="checkbox"/> Internet
<input type="checkbox"/> Nuclear
<input checked="" type="checkbox"/> Out of State
<input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Off-site Cognitive Services
<input type="checkbox"/> Parenteral
<input type="checkbox"/> Parenteral (outpatient)
<input type="checkbox"/> Outpatient/Discharge
<input checked="" type="checkbox"/> Mail Service
<input type="checkbox"/> Long Term Care |
|---|---|

60992

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: MP or MW _____)	
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: Airgas USA, LLC

Physical Address: 389 N. Industrial Rd. #1, St. George, UT 84770

(This must be a business address, we can not issue a license to a home address)

Mailing Address: Same as above

City: _____ State: _____ Zip Code: _____

Telephone: (435) 628-9353 Fax: (435) 628-0474

E-mail: Jared.Lott@airgas.com Website: www.airgas.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8:00 am to 5:00 pm Tue: 8:00 am to 5:00 pm Wed: 8:00 am to 5:00 pm Thu: 8:00 am to 5:00 pm

Fri: 8:00 am to 5:00 pm Sat: N/A to N/A Sun: N/A to N/A Holidays: N/A to N/A

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Jared Lott

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- | | |
|--|---|
| <input checked="" type="checkbox"/> Medical Gases** | <input type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | Other: _____ |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: Jared Lott

Telephone: (435) 628-9353

NEVADA STATE BOARD OF PHARMACY

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\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: MP or MW _____)
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership – Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: BONRO MEDICAL INC.

Physical Address: 4490 WASHINGTON ROAD BLDG. 100 STE. 16
(This must be a business address, we can not issue a license to a home address)

Mailing Address: P.O. BOX 1880

City: EVANS State: GA Zip Code: 30809-3800

Telephone: 706.210.4730 Fax: 706.210.4740

E-mail: groese@bonro.com Website: www.bonro.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9am to 5pm Tue: 9am to 5pm Wed: 9am to 5pm Thu: 9am to 5pm

Fri: 9am to 5pm Sat: — to — Sun: — to — Holidays: — to —

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: GEORGE P. ROOSE III - PRESIDENT/CFO

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- ☐ Medical Gases**
- ☐ Respiratory Equipment**
- ☐ Life-sustaining equipment**
- ☐ Diabetic Supplies

- ☐ Assistive Equipment
- ☐ Parenteral and Enteral Equipment**
- ☒ Orthotics and Prosthetics

Other: MALE SEXUAL Dysfunction - VACUUM DEVICES

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: N/A

Telephone: N/A

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: MP or MW _____)	
<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership – Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: CBS Medical Inc

Physical Address: 206 S. 13th Ste 600 Lincoln, NE 68508
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 206 S. 13th Ste 600

City: Lincoln State: NE Zip Code: 68508

Telephone: 402-904-4602 Fax: 402-904-4603

E-mail: ccarlson@cbomedicalequipment.com Website: www.cbomedicalequipment.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 7:00 to 9:00 am Tue: 7:00 to 9:00 am Wed: 7:00 to 9:00 am Thu: 7:00 to 9:00 am

Fri: 8:00 to 5:00 pm Sat: 10:00 to 5:00 pm Sun: to Holidays: to Closed

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Curtis Carlson

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- | | |
|--|--|
| <input type="checkbox"/> Medical Gases** | <input checked="" type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input checked="" type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | Other: _____ |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: MP or MW _____)
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership – Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: DiabeticSupplies.com

Physical Address: 107 SW 13th Ave, Battle Ground, WA 98604
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 2210 W Main St, Suite 107-388

City: Battle Ground State: WA Zip Code: 98604

Telephone: 877-787-7543 Fax: 360-723-9030

E-mail: customerservice@diabeticsupplies.com Website: diabeticsupplies.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 7:30 to 4:30 Tue: 7:30 to 4:30 Wed: 7:30 to 4:30 Thu: 7:30 to 4:30
Fri: 7:30 to 4:30 Sat: closed Sun: closed Holidays: closed

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Bryan Luna, MPH, RD, CPed

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- ☐ Medical Gases**
- ☐ Respiratory Equipment**
- ☐ Life-sustaining equipment**
- ☒ Diabetic Supplies

- ☒ Assistive Equipment
- ☐ Parenteral and Enteral Equipment**
- ☒ Orthotics and Prosthetics
- Other: syringes/pen needles, footwear & therapeutic inserts

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____

Telephone: _____

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: MP or MW _____)
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: Joint Active Systems, Inc.

Physical Address: 2600 S. Raney Street Effingham, IL 6240
(This must be a business address, we can not issue a license to a home address)

Mailing Address: PO Box 1367

City: Effingham State: IL Zip Code: 62401

Telephone: 217-342-3412 Fax: 217-347-3384

E-mail: lworkman@jointactivesystems.com Website: www.jointactivesystems.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8 to 5 Tue: 8 to 5 Wed: 8 to 5 Thu: 8 to 5

Fri: 8 to 5 Sat: - to - Sun: - to - Holidays: - to -

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Boris Bonutti

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- | | |
|--|--|
| <input type="checkbox"/> Medical Gases** | <input type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input checked="" type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | Other: <u>ROM Devices</u> |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: N/A Telephone: _____

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NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane -- Reno, NV 89509 -- (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: MP or MW _____)	
<input type="checkbox"/> Publicly Traded Corporation -- Pages 1,2,3,4	<input type="checkbox"/> Partnership -- Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation -- Pages 1,2,3,5	<input type="checkbox"/> Sole Owner -- Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: NIPRO MEDICAL CORPORATION

Physical Address: 3731 DISTRILEX DR N MEMPHIS TN 38118
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 3150 NW 107th Ave.

City: Miami State: FL Zip Code: 33172

Telephone: 305.599.7174 Fax: 305.592.4421

E-mail: jessica.o@nipromed.com Website: WWW.NIPRO.COM

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 9 to 5 Tue: 9 to 5 Wed: 9 to 5 Thu: 9 to 5

Fri: 9 to 5 Sat: - to - Sun: - to - Holidays: - to -

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: JOSE MARTINEZ.

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

☐ Medical Gases**

☐ Respiratory Equipment**

☐ Life-sustaining equipment**

☐ Diabetic Supplies

☐ Assistive Equipment

☐ Parenteral and Enteral Equipment**

☐ Orthotics and Prosthesis

Other: Legend devices (wholesale)

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: Jessica Oswald

Telephone: 305.599.7174 x249

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: MP or MW _____)
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: Philips Healthcare, a division of Philips Electronics North America Corporation

Physical Address: 22100 Bothell Everett Hwy, Bothell, WA 98021
(This must be a business address, we can not issue a license to a home address)

Mailing Address: Philips Healthcare, Attn: Peggy Erb, 3000 Minuteman Road

City: Andover State: MA Zip Code: 01810

Telephone: 425-487-7000 Fax: 425-487-7758

E-mail: stein.oettle@philips.com Website: www.healthcare.philips.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8 am to 5 pm Tue: 8 am to 5 pm Wed: 8 am to 5 pm Thu: 8 am to 5 pm

Fri: 8 am to 5 pm Sat: Closed Sun: Closed Holidays: Closed

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Stein E. Oettle

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- | | |
|--|---|
| <input type="checkbox"/> Medical Gases** | <input type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | <input checked="" type="checkbox"/> Other: <u>Prescription and Non-Prescription Medical Devices</u> |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☐ New MDEG ☒ Ownership Change (PLEASE SEE ADDENDUM)
(Please provide current license number if making changes: MP or MW 00739)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6
☒ Non Publicly Traded Corporation – Pages 1,2,3,5 ☐ Sole Owner – Pages 1,2,3,7

Please check box for type of ownership and complete correct part of the application.

Facility Name: PHYSIO-CONTROL, INC.

Physical Address: 11811 WILLOWS RD NE

(This must be a business address, we can not issue a license to a home address)

Mailing Address: (SAME)

City: REDMOND State: WA Zip Code: 98001

Telephone: (425) 867-4000 Fax: (425) 861-4227

E-mail: lynn.retallick@physio-control.com Website: www.physio-control.com

Mon: 7am to 5pm Tue: 7am to 5pm Wed: 7am to 5pm Thu: 7am to 5pm

Fri: 7am to 5pm Sat: to Sun: to Holidays: to

Name: BRIAN D. WEBSTER, PRESIDENT

☐ Medical Gases**
☐ Respiratory Equipment**
☒ Life-sustaining equipment**
☐ Diabetic Supplies

☐ Assistive Equipment
☐ Parenteral and Enteral Equipment**
☐ Orthotics and Prosthesis
 Other: _____

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: JERRY BENTLEY Telephone: (800) 442-1142 x 72676

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: MP or MW _____)
<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input checked="" type="checkbox"/> Partnership – Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: Strive Medical LLC
Physical Address: 8428 Sterling St. Suite B Irving, TX 75061
(This must be a business address, we can not issue a license to a home address)
Mailing Address: 8428 Sterling St. Suite B
City: Irving State: TX Zip Code: 75063
Telephone: 972-354-7300 Fax: 972-354-7311
E-mail: JROSENTHAL@STRIVEMEDICAL.COM Website: www.strive-medical.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8 to 5 Tue: 8 to 5 Wed: 8 to 5 Thu: 8 to 5
Fri: 8 to 5 Sat: _____ to _____ Sun: _____ to _____ Holidays: _____ to _____

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Josh Rosenthal

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- | | |
|--|--|
| <input type="checkbox"/> Medical Gases** | <input type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | <input checked="" type="checkbox"/> Other: <u>Urological and wound care supplies</u> |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE MDEG LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

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<input checked="" type="checkbox"/> New MDEG	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: MP or MW _____)
<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership – Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

FACILITY INFORMATION

Facility Name: Theratech, Inc.

Physical Address: 1109 Myatt Blvd. Madison, TN 37115
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 1109 Myatt Blvd.

City: Madison State: TN Zip Code: 37115

Telephone: 615-865-4000 Fax: 615-860-5900

E-mail: mprice@pssd.com Website: www.stimsupply.com

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 8 to 5 Tue: 8 to 5 Wed: 8 to 5 Thu: 8 to 5

Fri: 8 to 5 Sat: to Sun: to Holidays: to

MDEG ADMINISTRATOR INFORMATION: Person in charge on a daily basis

Name: Mike Price

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- | | |
|--|--|
| <input type="checkbox"/> Medical Gases** | <input checked="" type="checkbox"/> Assistive Equipment |
| <input type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input checked="" type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | Other: <u>nebulizers</u> |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact.

Name: _____ Telephone: _____

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: WH _____)
--	--

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

N/A - Eon Labs, Inc. (Eon) is wholly owned by Novartis Pharmaceutical Corp., a publicly traded company. As confirmed with your office, because Eon is wholly owned by a publicly traded company, the publicly traded corporation section should be completed.

GENERAL INFORMATION

Facility Name: Eon Labs, Inc.

Physical Address: 4700 Sandoz Drive, Wilson, NC 27893

Mailing Address: 4700 Sandoz Drive

City: Wilson State: NC Zip Code: 27893

Telephone: 252-234-2222 Fax: 252-234-2600

Toll Free Number: 800-525-8747

E-mail: jonathan.rushford@sandoz.com Website: www.us.sandoz.com

Facility Manager: Jonathan Rushford

Professional qualifications and experience of facility manager: See Attachment C

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☒ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☒ Poisons or Chemicals ☐ Veterinary Legend Drugs
☒ Controlled Substances (include copy of DEA) See Attachment B
☐ Other: _____

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NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☒ New Wholesaler ☐ Ownership Change
(Please provide current license number if making changes: WH_____)

☐ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6
☒ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: Freedom Pharmaceuticals, Inc.

Physical Address: 5867 S. Garnett Rd.

Mailing Address: 5867 S. Garnett Rd.

City: Tulsa State: OK Zip Code: 74146

Telephone: 918-615-6228 Fax: 918-615-6248

Toll Free Number: 1-877-839-8547

E-mail: info@freedomrxinc.com Website: www.freedomrxinc.com

Facility Manager: Take Jackson, President - CEO

Professional qualifications and experience of facility manager: See enclosed resume.

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☐ Hospitals ☐ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☒ Controlled Substances (include copy of DEA)
☐ Other: _____

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane Reno, NV 89509 (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

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☒ New Wholesaler ☐ Ownership Change
(Please provide current license number if making changes: WH _____)

☒ Publicly Traded Corporation Pages 1,2,3,4 ☐ Partnership - Pages 1,2,3,6
☐ Non Publicly Traded Corporation Pages 1,2,3,5a,5b ☐ Sole Owner Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: Healthcare Distribution Specialists
Physical Address: 9337 Fraser Ave.
Mailing Address: 9337 Fraser Ave
City: Silver Spring State: MD Zip Code: 20916
Telephone: 888-912-4437 Fax: 240-235-4370
Toll Free Number: 888-912-4437
E-mail: jamie@hdspharm.com Website: www.hdspharm.com
Facility Manager: Matthew Swift
Professional qualifications and experience of facility manager: Over 10 years in the industry in a management role.

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☒ Hospitals ☐ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☐ Controlled Substances (include copy of DEA)
☐ Other: _____

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NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
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<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH _____)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Methapharm, Inc
Physical Address: 11712 W Sample Road
Mailing Address: same as above
City: Coral Springs State: FL Zip Code: 33005
Telephone: 954-341-502 Fax: 954-341-3588
Toll Free Number: OTAS
E-mail: ngomez@methapharm.com Website: www.methapharm.com
Facility Manager: Nancy Gomez
Professional qualifications and experience of facility manager: See attached

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

<input checked="" type="checkbox"/> Legend Pharmaceuticals, Supplies or Devices	<input type="checkbox"/> Hypodermic Devices
<input type="checkbox"/> Poisons or Chemicals	<input type="checkbox"/> Veterinary Legend Drugs
<input type="checkbox"/> Controlled Substances (include copy of DEA)	
<input type="checkbox"/> Other: _____	

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH _____)	

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Midwest Veterinary Supply, Inc.
Physical Address: 5374 Maly Road, Sun Prairie, WI 53590
Mailing Address: 11965 Larc Industrial Blvd., Burnsville, MN 55337
City: Burnsville State: MN Zip Code: 55337
Telephone: 952-894-4350 Fax: 952-894-5407
Toll Free Number: 800-328-2975
E-mail: marcia.meling@midwestvet.net Website: www.midwestvet.net
Facility Manager: Paul Crary
Professional qualifications and experience of facility manager: see attached resume

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☒ Practitioners ☐ Hospitals ☐ Wholesalers
☐ Other: We sell only to licensed veterinarians

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☒ Hypodermic Devices
☒ Poisons or Chemicals ☒ Veterinary Legend Drugs
☒ Controlled Substances (include copy of DEA)
☐ Other: _____

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE
CORPORATION

FEE \$500.00 (non-refundable and not transferable)
Application must be printed legibly

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

New Wholesaler ☒ Ownership Change _____ Name Change _____ Location Change _____
(Please provide current license number if making changes: WH _____)

GENERAL INFORMATION

Facility Name: Noramco, Inc.

Physical Address: 1440 Olympic Drive, Athens, GA 30601

Mailing Address: 1440 Olympic Drive

City: Athens State: GA Zip Code: 30601

Telephone Number: 706.353.4514 Fax Number: 706.425.3607

Toll Free Number: N/A

E-mail: ahaynes@its.jnj.com Website: www.noramco.com

Facility Manager: Amanda Haynes

Professional qualifications and experience of facility manager: 20 years experience with Noramco

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☒ ~~Wholesalers~~ ^{Manufacturers}

Type of Products to be handled or wholesaled:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☒ Controlled Substances (include copy of DEA) ☐ Parenterals
☐ Other: _____

Licensed as a Manufacturer by the FDA? ☒ Yes ☐ No, If yes include a copy of the FDA registration.

Board Use Only

Received: AUG 23 2012 Check Number: _____ Amount: 500.00

60864

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change (Please provide current license number if making changes: WH_____)
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<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: PERRIGO PHARMACEUTICALS COMPANY

Physical Address: 110 Hidden Lake Circle, Duncan, SC 29334

Mailing Address: c/o State License Servicing, 321 Route 94 South, Warwick, NY 10990

City: _____ State: _____ Zip Code: _____

Telephone: Facility: 269-673-8451 Facility: 269-686-1655
Licensing: 845-544-2482 Fax: Licensing: 845-544-2481

Toll Free Number: _____

E-mail: PPC@slsny.com Website: www.perrigo.com

Facility Manager: Dennis W. Miller

Professional qualifications and experience of facility manager: PLEASE SEE ATTACHED
RESUME OF DENNIS MILLER

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☐ Practitioners ☐ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☐ Controlled Substances (include copy of DEA)
☒ Other: OTC drugs (including List I), dietary supplements, OTC medical devices, cosmetics

61039

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: PERRIGO PHARMACEUTICALS COMPANY

Physical Address: 3896 58th Street, Holland, MI 49423

Mailing Address: c/o State License Servicing, 321 Route 94 South, Warwick, NY 10990

City: _____ State: _____ Zip Code: _____

Telephone: Facility: 269-673-8451 Facility: 269-686-1655
Licensing: 845-544-2482 Fax: Licensing: 845-544-2481

Toll Free Number: 1-800-827-2296

E-mail: PPC@slny.com Website: www.perrigo.com

Facility Manager: David Smalla

Professional qualifications and experience of facility manager: Please see attached resume

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☒ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☐ Controlled Substances (include copy of DEA)
☒ Other: OTC drugs (including List I), dietary supplements, OTC medical devices, cosmetics

manufacturer

60983

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: PERRIGO PHARMACEUTICALS COMPANY

Physical Address: 1692 12TH STREET, SUITE C, MARTIN, MI 49070

Mailing Address: STATE LICENSE SERVICING, 321 ROUTES 94 SOUTH, WARWICK, NY 10990

City: Martin State: MI Zip Code: 49070

Telephone: FACILITY: 269-686-1655 LICENSING: 845-544-2482 Fax: FACILITY: 269-686-1828 LICENSING: 845-544-2481

Toll Free Number: 866-634-9120

E-mail: PPC@SLSNY.COM

Website: WWW.PERRIGO.COM

Facility Manager: DAVID SMALLA

Professional qualifications and experience of facility manager: PLEASE REFER TO ATTACHED RESUME

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☐ Practitioners ☒ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☐ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☐ Controlled Substances (include copy of DEA)
☒ Other: OTC DRUGS (INCLUDING LIST 1 PSEUDOEPHEDRINE), OTC MEDICAL DEVICES & COSMETICS

manufacturer

60982

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input type="checkbox"/> New Wholesaler	<input checked="" type="checkbox"/> Ownership Change
(Please provide current license number if making changes: <u>WH01119</u>)	

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: REBEL DISTRIBUTORS, CORP.

Physical Address: 3607 OLD CONEJO ROAD THOUSAND OAKS, CA 91320

Mailing Address: 4345 SATHPOINT BLVD

City: Jacksonville State: FL Zip Code: 32216

Telephone: (904) 332-3000 Fax: (904) 332-3349

Toll Free Number: n/a

E-mail: estutman@psd.com Website: www.rebelrx.com

Facility Manager: DASTRY SETSER

Professional qualifications and experience of facility manager: LICENSED DESIGNATED REPRESENTATIVE FOR CA, CMT

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☒ Practitioners ☐ Hospitals ☐ Wholesalers

☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices

☐ Poisons or Chemicals ☐ Veterinary Legend Drugs

☒ Controlled Substances (include copy of DEA)

☐ Other: _____

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR OUT-OF-STATE WHOLESALER LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New Wholesaler	<input type="checkbox"/> Ownership Change
(Please provide current license number if making changes: WH_____)	

<input checked="" type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,4	<input type="checkbox"/> Partnership - Pages 1,2,3,6
<input type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,3,5a,5b	<input type="checkbox"/> Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION

Facility Name: Smith & Nephew, Inc.

Physical Address: 4231 S. Natches Ct., Units B & C, Englewood, CO 80110

Mailing Address: c/o Business Licenses LLC, PO Box 867

City: Monsey State: NY Zip Code: 10952

Telephone: 303-232-4231 Fax: 800-305-3933

Toll Free Number: 800-821-5700

E-mail: Joseph.Haynie@smith-nephew.com Website: www.smith-nephew.com

Facility Manager: Joseph Haynie

Professional qualifications and experience of facility manager: Attached

Types of licensed outlets or authorized persons firm will serve:

☐ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled be firm:

<input checked="" type="checkbox"/> Legend Pharmaceuticals, Supplies or Devices	<input type="checkbox"/> Hypodermic Devices
<input type="checkbox"/> Poisons or Chemicals	<input type="checkbox"/> Veterinary Legend Drugs
<input type="checkbox"/> Controlled Substances (include copy of DEA)	
<input type="checkbox"/> Other: _____	

PT

60978

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR NEVADA PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input type="checkbox"/> New Pharmacy	<input type="checkbox"/> Ownership Change	<input checked="" type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: PH 02659 - Catalyst Mail)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7,8a,8b	<input type="checkbox"/> Partnership - Pages 1,2,5,7,8a,8b
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7,8a,8b
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Catamaran Home Delivery (New Name)

Physical Address: 6225 Annie Oakley Drive, Suite 400

Mailing Address: Same as above

City: Las Vegas State: NV Zip Code: 89120

Telephone: 702-436-8654 Fax: 702-436-8452

Toll Free Number: 800-225-9178

E-mail: corporatelicensing@accrediohealth.com Website: _____

Managing Pharmacist: James Stupnik License Number: 09792

Hours of Operation:

Monday thru Friday <u>8:00</u> am <u>5:30</u> pm	Saturday _____ am _____ pm
Sunday _____ am _____ pm	24 Hours <u>No</u>

TYPE OF PHARMACY

SERVICES PROVIDED

- ☒ Retail
- ☐ Hospital (# beds _____)
- ☐ Internet
- ☐ Nuclear
- ☐ Out of State
- ☐ Ambulatory Surgery Center

- ☐ Off-site Cognitive Services
- ☐ Parenteral
- ☐ Parenteral (outpatient)
- ☐ Outpatient/Discharge
- ☒ Mail Service
- ☐ Long Term Care

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR NEVADA PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

<input checked="" type="checkbox"/> New Pharmacy	<input type="checkbox"/> Ownership Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Location Change
(Please provide current license number if making changes: PH _____)			

<input type="checkbox"/> Publicly Traded Corporation – Pages 1,2,3,7,8a,8b	<input type="checkbox"/> Partnership - Pages 1,2,5,7,8a,8b
<input checked="" type="checkbox"/> Non Publicly Traded Corporation – Pages 1,2,4a,4b,7,8a,8b	<input type="checkbox"/> Sole Owner – Pages 1,2,6,7,8a,8b
Please check box for type of ownership and complete correct part of the application.	

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: Sierra Pharmacy Services, Inc.

Physical Address: 601 Mill Street

Mailing Address: 601 Mill Street

City: Reno State: Nevada Zip Code: 89502

Telephone: 775-786-9585 Fax: 775-786-9339

Toll Free Number: _____

E-mail: dlat1957@yahoo.com Website: _____

Managing Pharmacist: Dennis Latino, R.Ph. License Number: 11319

Hours of Operation:

Monday thru Friday <u>6</u> am <u>4:30</u> pm	Saturday <u>4</u> am <u>9 am</u> pm
Sunday <u>4</u> am <u>9 am</u> pm	24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

<input checked="" type="checkbox"/> Retail <input type="checkbox"/> Hospital (# beds _____) <input type="checkbox"/> Internet <input checked="" type="checkbox"/> Nuclear <input type="checkbox"/> Out of State <input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Off-site Cognitive Services <input type="checkbox"/> Parenteral <input type="checkbox"/> Parenteral (outpatient) <input type="checkbox"/> Outpatient/Discharge <input type="checkbox"/> Mail Service <input type="checkbox"/> Long Term Care
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61204

NEVADA STATE BOARD OF PHARMACY
431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440
APPLICATION FOR NEVADA WHOLESALE LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier's check only)
Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☒ New Wholesaler ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: WH _____)

☒ Publicly Traded Corporation – Page 1,2,3,4 ☐ Partnership - Page 1,2,3,6a,6b
☐ Non Publicly Traded Corporation – Page 1,2,3,5a,5b ☐ Sole Owner – Page 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION

Facility Name: TheraCom, L.L.C.

Physical Address: 5360 Capital Court, Suite 102, Reno, Nevada 89502

Mailing Address: 5360 Capital Court, Suite 102

City: Reno State: Nevada Zip Code: 89502

Telephone: 775-857-2170 Fax: 775-857-2757

Toll Free Number: N/A

E-mail: robert.salvador@absbg.com Website: www.thera.com

Facility Manager: Robert A. Salvador, Jr.

Professional qualifications and experience of facility manager: See Exhibit A (Resume)

Types of licensed outlets or authorized persons firm will serve:

☒ Pharmacies ☒ Practitioners ☒ Hospitals ☒ Wholesalers
☐ Other: _____

Type of Products to be handled or wholesaled by firm:

☒ Legend Pharmaceuticals, Supplies or Devices ☐ Hypodermic Devices
☐ Poisons or Chemicals ☐ Veterinary Legend Drugs
☐ Controlled Substances (include copy of DEA)
☐ Other: _____

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

APPLICATION FOR NEVADA Medical Device, Equipment & Gases (MDEG)

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

☒ New MDEG ☐ Ownership Change ☐ Name Change ☐ Location Change
(Please provide current license number if making changes: MP or MW _____)

☒ Publicly Traded Corporation – Pages 1,2,3,4 ☐ Partnership – Pages 1,2,3,6
☒ Non Publicly Traded Corporation – Pages 1,2,3,5a,5b ☐ Sole Owner – Pages 1,2,3,7
Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

MDEG Name: Accellence Home Medical DBA: ProMed

Physical Address: 4815 W. RUSSELL LAS VEGAS, NV 89118
(This must be a business address, we can not issue a license to a home address)

Mailing Address: 35 N. EDISON WAY SUITE 37 RENO, NV 89502

City: RENO State: NV Zip Code: 89502

Telephone: (702) 740-4138 Fax: (702) 740-4153

E-mail: ACCELLENCE@NVBELL.NET Website: _____

DAYS AND HOURS THAT THE FACILITY WILL BE REGULARLY OPERATING

Mon: 10 to 2 Tue: 10 to 2 Wed: 10 to 2 Thu: 10 to 2
Fri: 10 to 2 Sat: CLOSED Sun: CLOSED Holidays: CLOSED

MDEG ADMINISTRATOR INFORMATION (MDEG administrator application required)

Name: ACCELLENCE HOME MEDICAL / Bret Tracy

TYPE OF MDEG PRODUCTS THAT WILL BE SOLD (CHECK ALL APPLICABLE)

- | | |
|---|---|
| <input checked="" type="checkbox"/> Medical Gases** | <input checked="" type="checkbox"/> Assistive Equipment |
| <input checked="" type="checkbox"/> Respiratory Equipment** | <input type="checkbox"/> Parenteral and Enteral Equipment** |
| <input type="checkbox"/> Life-sustaining equipment** | <input type="checkbox"/> Orthotics and Prosthesis |
| <input type="checkbox"/> Diabetic Supplies | Other: _____ |

**If providing these types of services you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact. Name: JOHN HOWITT Telephone: 775 843-8690

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